AN EXPLORATORY STUDY OF REFERRAL AND INTAKE PROCEDURE WITHIN THE PSYCHIATRIC CLINIC AT THE STATE PRISON OF SOUTHERN MICHIGAN

By

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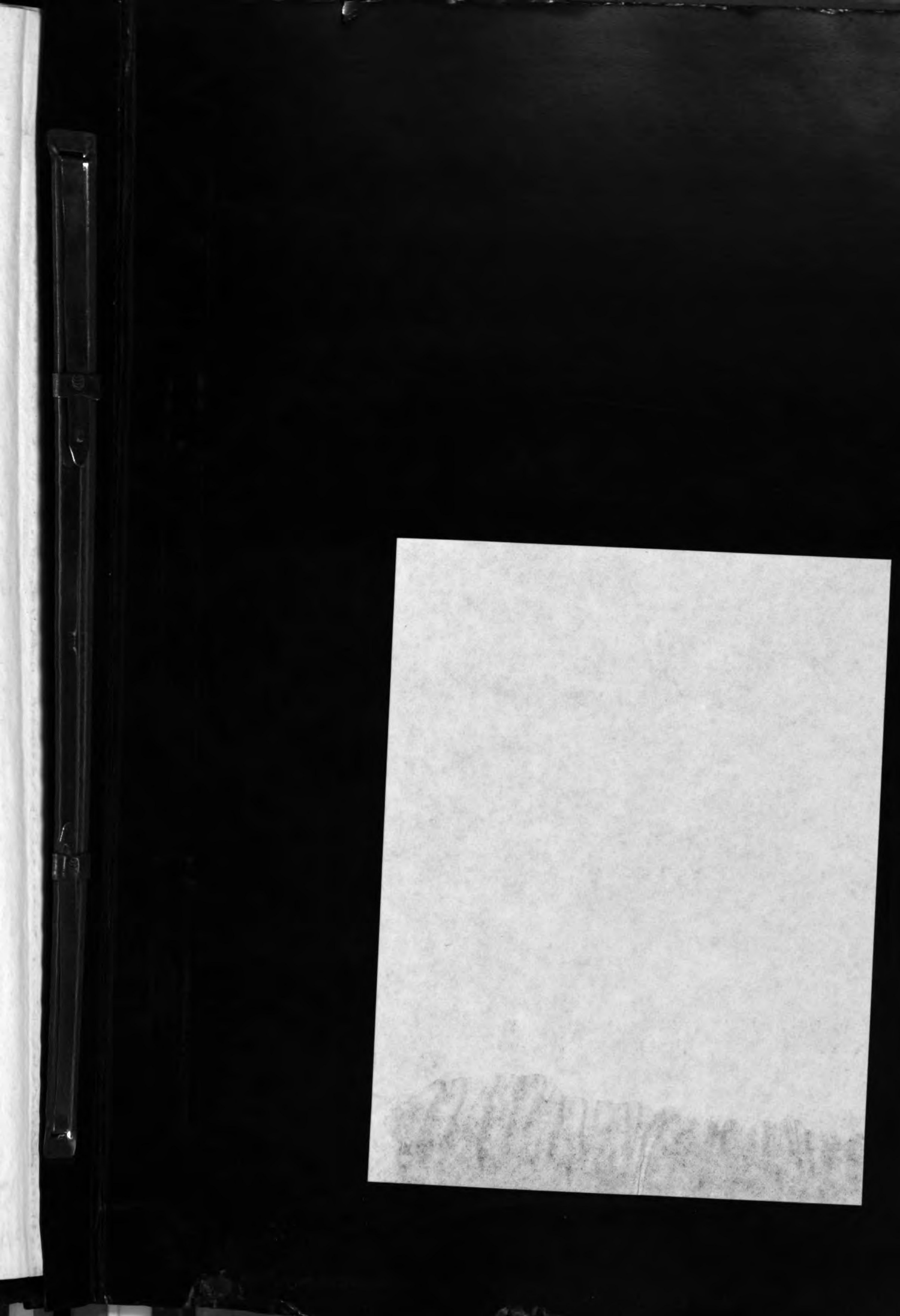

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Approved: Gordon J. Aldridge
Chairman, Research Committee

Ernest B. Harper
Director of School

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CHAPTER I

INTRODUCTION

A study of referral and intake procedures in a psychiatric clinic is one means of gaining understanding of how a clinic relates to its community. Certain emphasis should be placed on the intake process inasmuch as the activities of the agency are directly related to those cases accepted or rejected during the intake period.

The intake process in social welfare agencies is the initial contact or series of contacts made with the client or patient for the purpose of helping him move as realistically as possible toward appropriate help. Hamilton stressed the importance of helping the patient to progress toward help when she wrote, "Techniques have been developed to induce the person to move from readiness to ask for help ... toward readiness to use help."[1]

During 1954, John Davis, a second-year student at the Department of Social Work, Michigan State College, conducted a research project while completing his field work at the

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1 Gordon Hamilton, "Helping People - The Growth of a Profession.", Journal of Social Casework, Vol. XXIX, No. 8, 1948, p. 294.

Psychiatric Clinic at State Prison of Southern Michigan.[2] John Davis, who began his work in the Psychiatric Clinic as a student social worker one year after the clinic was formally organized, became interested in exploring referrals to the clinic, their sources, and the reasons for referrals, attempting to examine the intake process at that time.

Reason for Study

The writer discussed several research possibilities with the Social Work Supervisor at the clinic. One possibility was to conduct a follow-up study of the referral process to the clinic, comparing the findings to those of John Davis' study. This writer chose to conduct a comparative study of the referral process at the Psychiatric Clinic, State Prison of Southern Michigan, since it was felt that the findings could be of value to the clinic in re-examining its intake process two years following the previous study. The writer had an interest in such a research project in that it helped him to become better acquainted with many of the functions of the agency, making the field experience there a more meaningful one.

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2. John Davis, "An Exploratory Study of Referrals and Intake Procedures within the Psychiatric Clinic at State Prison of Southern Michigan" (unpublished Master's Research Project Report, Department of Social Work, Michigan State University, 1955.)

Review of Literature

There is a vast amount of literature available about crime and its dynamics. The wave of prison riots which came to a head during the early 1950's stimulated public awareness of conditions existing within prisons.

The prison riot of April, 1952 at the State Prison of Southern Michigan supported charges that dangerous inmates were often housed and mixed indiscriminately with the general population of the prison. The need for more psychiatric services within the Corrections Department became apparent.

It has been estimated that at least two or three percent of all prison admissions are psychotic, and that possibly an equal number develop psychotic trends during confinement.[3]

While it is generally agreed that much is to be desired in achieving penal reformation, writers such as John Bartlow Martin have exposed to the American public the conditions that have existed in penal institutions.[4]

With the advent of various reforms after many bloody riots throughout penal institutions, it was to be expected that more facilities would be forthcoming which would hope-

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3 Paul Tappan, Contemporary Correction, New York: McGraw-Hill, 1951, p. 191.

4 John Bartlow Martin, Break Down the Walls, New York, Curtis Publishing Company, 1953.

fully focus on rehabilitation rather than punishment of inmates.

Literature about our prisons has emphasized the need for trade training and more adequate preparation of the individual to take his place upon rejoining free society. It has been recognized that psychiatric services could be of great help within the penal systems. However, it seems evident that rehabilitation has not been put into effect nearly as much as it has been discussed. Robert Currie, who also completed a research project at the Psychiatric Clinic, State Prison of Southern Michigan, while a second-year student at the Department of Social Work, Michigan State College, found that there were only six psychiatric clinics in adult male prisons in the United States which had a professional staff consisting of a psychiatrist, a psychologist, and a social worker, engaged in practicing the clinical "team" approach.[5]

There is a lack of literature dealing with psychiatric clinics in prisons. This may be explained on the basis that there are so few clinics operating in prison settings. There is a tendency to finance physical-structural changes first. With so many of our prisons from fifty to one hundred years

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5 Robert L. Currie, "An Exploratory Investigation of Personnel Standards, Social Service Practices, and Current Trends within the Psychiatric Clinics in Selected United States' Adult Male Prisons" (unpublished Master's Research Project Report, Department of Social Work, Michigan State University, 1955), p. 24.

old, the need for expansion and newer facilities becomes one of the more pressing problems for legislatures. Although there seems to be recognition of the services a psychiatric clinic may offer a corrections department, it seems that capital outlay for bringing penal institutions up to date is directed toward improvement of needed physical structures first, and examination of psychiatric services afterward.

CHAPTER II

PROBLEM, QUESTIONS, AND PROCEDURE

Problem

When the present study began, the clinic had been in operation for three years. Numerous changes involving staff, policies, and attitudes had occurred during this period.

This study was concerned with examining the referral and intake procedures of the Psychiatric Clinic, State Prison of Southern Michigan. The central problem was to determine if there were any differences in the referral and intake process for the months of October 1, 1956 through December 31, 1956 from those of the same period in 1954.

Questions

A leading question was whether the inception of a new Reception-Diagnostic Center on February 1, 1956 would modify the source of referrals to the clinic. It was felt that many emotionally disturbed inmates would be detected during the "screening" process before their assignment into one of the Corrections programs.[6] The writer wondered if the relation-

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6 A psychiatrist serving three-fifths time, three psychologists on full time, and four full-time social workers were employed in the Reception-Diagnostic Center.

ship of the Psychiatric Clinic to the Reception-Diagnostic Center had caused changes in the intake procedure of the clinic. Secondly, inasmuch as it had been two years since the last study, a question arose as to how various departments interpreted the clinic's functions since they had had an opportunity to become better acquainted with the clinic.

Procedure

The central problem was to determine if there were any differences in the referral and intake process since John Davis' study in 1954. Beginning this study with the intention of comparing findings with those of the 1954 study, certain problems arose. In attempting to use John Davis's schedule, it became apparent that a new schedule was necessary in order to examine current referral procedures, in view of the lack of available data which John Davis encountered during the first year of the clinic's operation. Therefore, the present study cannot be considered a comparative study, since a different schedule was used and different data obtained. The writer will compare data of a similar nature when meaningful.[7]

In order to determine the sources of referrals made to the clinic for the last quarter of 1956, it was necessary to examine file cards which list inmate numbers and dates of referral. There were found to be 299 referrals made to the Psychiatric Clinic during the last quarter of 1956. Duplicate

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7 See two schedules in appendix.

referrals carried over from a previous month were eliminated.

Using the inmate numbers located in the files, the next step was to examine individual patient folders which were filed according to number. All patients referred to the clinic had a folder started with their first contact. It should be mentioned that at the time of the 1954 study only those patients who were retained as in-patients had available records indicating the dates of referral, disposition, etc. No records were kept of patients who did not remain in the clinic.

As a means of selecting appropriate cases to be used for the study, it was decided that patients who were receiving psychiatric treatment or services on a call basis would be omitted. Generally, in order to avoid duplication, patients receiving psychiatric services were not included as referrals, in that a regular schedule for treatment already existed. After a number of patient folders were examined, there were found to be many re-referrals made within a relatively short period. Often, such re-referrals were made for incidental and non-clinical services, but were included statistically as "new" referrals. Each new contact by the clinic is designated as a referral unless the patient is on a specified plan of treatment. No referrals were used more than one time during the three-month period. Limitation of

the number of times a referral could be used was necessary as a result of some referrals constituting a disproportionate number of contacts with the clinic. In a sense, this group was similar to those patients who were on a call basis. They were receiving regular psychiatric treatment or services and were not considered referrals as such. John Davis' study also eliminated patients in treatment, and is comparable to the present study in this respect.

CHAPTER III

SETTING

Physical Setting of Clinic

The Psychiatric Clinic at the State Prison of Southern Michigan was formally established on October 1, 1953, with Dr. Warren S. Wille as its Director. It is located within the fifth tier of what is known as "Top 6", and includes an adjoining area located on the upper floor of the Rotunda. The writer will refer to "Top 6" and "Lower 6" as a means of distinguishing the Psychiatric Clinic from the convalescent block beneath the clinic. "Lower 6" has four tiers of individual cells below the Psychiatric Clinic housing some 363 inmates, many of whom are epileptics, seniles, and some with emotional disorders in need of psychiatric services but able to function without being in the clinic. Many of these inmates have been former in-patients of the Psychiatric Clinic and continue to receive medication and psychiatric treatment from "Top 6", while others are convalescing and undergoing a period of observation which "Lower 6" offers. Some of these inmates spend a good portion of their sentences in "Lower 6" within its cellblock and adjoining outdoor play area which is fenced off and not in direct access to other inmates. Some eat and perform various chores within "Lower 6". Very few hold jobs in the general population, mainly as a result of

their mental or physical conditions. This results in their sitting a great deal of the time, except for recreational periods. It is recognized that lack of work within the institution, not only for this cellblock but for the entire population, is one of the more pressing problems of this institution.

It is felt that the majority of these inmates are able to function at their best with the type of supervision "Lower 6" offers. The custodial officer in charge of supervising this cellblock works closely with the Psychiatric Clinic, attending occasional staff meetings in the clinic, and discussing the individual patients as to what can be done to help them. The attempt has been made to alleviate some of the pressures these inmates have been unable to cope with in the general population. Since many of these inmates are unable to adapt to prison life within the general population, the protection "Lower 6" offers in the form of direct physical contact with "Top 6" in the event of needed therapy is valuable. The less rigid upholding of institutional rules and regulations makes this cellblock a place in which individual allowances are made for inmates with certain physical and emotional difficulties. The attempt has been to offer a therapeutic environment with some degree of isolation from the general population so that the inmate may regain his emotional equilibrium. Some are never able to make a satisfactory adjustment warranting placement outside this block.

Many of the senile and epileptic cases spend their entire sentences in "Lower 6". However, it is more common for these inmates to be moved to blocks representing the routine of prison life than to remain within the confines of this environment.

The fifth tier, or "Top 6", which houses the in-patients of the Psychiatric Clinic, contains 31 individual cells. Another 30 beds are located in the Rotunda in what is called the "open ward". The open ward consists of a dormitory arrangement for sleeping and a play area, each located in the Rotunda. Such games as pingpong, checkers, badminton, and shuffleboard are utilized. A small library is also located in a separate room of the Rotunda. An occupational therapy class is offered to in-patients as well as to out-patients who are located in "Lower 6". An inmate conducts these classes, assisted by another inmate and supervised by a member of the professional staff. The "closed ward" consists of 31 individual cells of which three are equipped for housing the violent patients who may hurt themselves or others if allowed out of their cells. The closed ward houses the more disturbed patients who are able to come out of their cells periodically, but are prone to become upset more easily than patients who stay in the Rotunda. Patients on the closed ward live in the block directly over "Lower 6", and have individual cells instead of the dormitory arrangement used in the Rotunda. Most new patients are housed in the closed ward

until their behavior warrants placement in the Rotunda, where most patients mix freely and are able to socialize with a minimum of acting out. Eating arrangements are separate, as are other necessary facilities.

There are 26 inmates employed in various capacities and living in individual cells in "Top 6". Of this number, seventeen are inmate nurses, there are four clerks, one "runner", a barber, a recreational therapist, and two occupational therapy instructors.

Separate offices are available for all members of the professional staff, and a new staff conference room has been added which doubles as a meeting place for group therapy as well as a movie projector sound room for Sunday movies.

Radio and television sets are available in both wards. Patients are encouraged to participate in outdoor activities at "yard time", which occurs about two hours per day. The same separate yard for outdoor activities is used by "Top 6" and "Lower 6", at different intervals of the day.

Reception-Diagnostic Center

Adjoining both "Lower 6" and "Top 6" is Cellblock Seven. This block houses the Reception-Diagnostic Center, otherwise known as the quarantine block. Inmates sentenced to state penal institutions in Michigan are processed through this center and assigned to one of the programs within the Corrections

Department.

New inmates receive inoculations to prevent diseases. They are also tested to determine personality characteristics, intelligence, and achievement. Their program may be largely defined by the results of tests taken while in quarantine. The length of stay for inmates in quarantine is about 30-45 days, and after this period they may be transferred to any of the penal institutions in the state.

The staff of the Reception-Diagnostic Center is comprised of a psychiatrist, three psychologists, and four social workers.

Professional Clinic Personnel

The Psychiatric Clinic personnel numbered 39 at the time of this writing. Of this number, 13 were non-inmate employees. There were three psychiatrists, one serving as the director of the clinic on a three-fifths time basis, a resident psychiatrist serving on a full-time basis, and a consulting psychiatrist from the University of Michigan whose services were available two days per month.

There were three full-time psychologists, each having a Master's degree in psychology. A fourth psychologist served as a consultant in psychology from Michigan State University and was available for consultation twice monthly.

The social work staff consisted of a full-time psychia-

tric social worker who assumed supervisory responsibilities for social work students and also directed the social work functions of the clinic. A social work student was employed on a half-time basis while completing second-year field work training in the School of Social Work at Michigan State University. An electroencephalogram technician conducted all electroencephalegram examinations and supervised the occupational therapy program.

Other non-inmate staff members consisted of two civilian male nurse supervisors and one secretary; the balance of 26 people employed by the clinic were inmates.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

There were 299 referrals made to the Psychiatric Clinic during the last quarter of 1956. Eliminating duplicate referrals and those referrals regarding patients receiving psychiatric services, there were found to be 198 referrals made to the clinic which met the criteria for this study. Of this number, 107 were new referrals and had had no previous contact with the clinic. The remaining 91 were re-referrals who had had some type of previous contact with the clinic prior to this study. The total number of 198 was substantially higher than the 135 referrals used in the 1954 study. The extent to which this number was higher has possibly been due to different criteria which this writer employed in determining those referrals to be used.

There were 69 referrals made in October, 79 referrals were made in November, and 50 referrals made in December, constituting the last quarter of 1956. These numbers did not appear to reflect any great significance in terms of numbers made for these individual months.

Sources of Referrals

The sources of referrals, indicating whether they were new or re-referrals, are illustrated in Table 1.

TABLE 1.

Sources of Referrals to the Psychiatric Clinic,
State Prison of Southern Michigan,
October 1, 1956 - December 31, 1956.

Referral Sources	Total	New Referrals	Re-Referrals
Total	198	107	91
Self	42	19	23
Custodial Personnel	39	13	26
Custody	24	10	14
Discipline Block	15	3	12
Hospital	31	21	10
Reception-Diagnostic Center	29	26	3
Individual Treatment	23	13	10
Classification	8	6	2
Counselor	15	7	8
Parole Board and Warden	15	5	10
Parole Board	10	5	5
Warden	5	0	5
Other Institutions	10	4	6
Miscellaneous	9	6	3
Work Supervisor	5	5	0
Chaplain	2	1	1
Other	2	0	2

Self-referrals were the largest source of referrals made to the Psychiatric Clinic during the period studied. They totaled 42, with 19 of this number new referrals and 23 re-referrals. These re-referrals were usually made by inmates writing a note of some nature to the clinic, requesting an interview regarding a problem.

Custodial personnel followed closely behind the leading number of referrals made to the clinic, with a total of 39. Included under this heading were the great number of custodial officers within the institution as well as the discipline block which consists of a separate group of custodial officers in charge of maintaining its operation. Although these two groupings, custody and discipline block, were basically members of custodial personnel, it was felt that the groups should be distinguished, inasmuch as a number of referrals were recognized as coming from a block in which discipline is made more rigid than that of the blocks making up the general institution.

Of the 39 referrals made by custodial personnel, 13 were new referrals and 26 were re-referrals. This referral source would have the most contact with inmates within the institution as a result of the nature of their jobs. Referrals were made from the deputy in charge of custody down through the ranks of various correctional officers employed in the institution. Custodial personnel re-referrals made a substantially large number, twice the number of new referrals. This may have been due to having contacts with ex-patients whom custody felt needed further services from the clinic. If it was known that a certain patient had been receiving services from the clinic, any further emotional display on his part might result in a re-referral. In the 1954 study, custodial personnel was the leading source of referrals to the clinic, followed by self referrals. It is noted that their positions were reversed

in this study.

The next largest source of referrals were those made by the hospital. This source consisted of 31 referrals, 21 of them new referrals and ten re-referrals.

The Reception-Diagnostic Center followed with 29 referrals. Of this number, 26 were new referrals, with three re-referrals. This new source of referrals made the fourth highest number of referrals to the clinic. The bulk of its referrals consisted of new referrals for psychiatric evaluation and treatment. A great number of these referrals required electroencephalogram examinations as a result of a history of "dizzy spells" and "seizures".

Individual Treatment was the next largest source of referrals with 23. This number consisted of 13 new referrals and ten re-referrals. Under this referral source were included the Classification Committee and the counselors of the institution.

The Parole Board and Warden referred 15 cases, of which five were new referrals and ten were re-referrals.

Other institutions made ten referrals, four new referrals and six re-referrals. In this grouping were included the Marquette Prison, Ionia Reformatory, and one of the prison camps.

The last referral source was a miscellaneous group

totaling nine referrals, six new referrals and three re-referrals making up this group. Within this group fell work supervisors, Chaplain, and in one case an inmate's wife who made the referral via the director of the clinic.

Cross-Classification of Sources and Stated Reasons for Referrals

The same groupings for reasons for referrals used in the 1954 study were used in this study. In many instances the same terminology stated in the referrals to the clinic was used in this study. In other instances it was necessary to interpret what category the stated reason for referral would fit.

Table 2 indicates that psychiatric evaluation was the most often-stated reason for referral to the clinic. According to the referrals, psychiatric evaluation was meant to effect an evaluation from the clinic in order to assist the referral source in making a decision regarding a particular case. In many instances the terminology used was a means of helping an inmate to obtain treatment of some nature, rather than for evaluation purposes only.

There were 77 referrals made for psychiatric evaluation. The Reception-Diagnostic Center led with 18 referrals in this category, while the hospital followed with 17, custodial personnel 12, Individual Treatment 11, Parole Board and Warden 11, self four, other institutions three, and miscellaneous sources

TABLE 2

Sources and Reasons for Referrals,
Psychiatric Clinic, State Prison of Southern Michigan
October 1, 1956 - December 31, 1956.

Referral Sources	Total	Stated Reasons for Referrals							
		Psychiatric Evalnation	Treatment	Non-Clinic Inquiry	Nervous	Bizarre Behavior	Emotionally Disturbed	Inability to Adjust	Other
Total	198	77	26	24	20	18	17	9	7
Self.....	42	4	2	24	6	1	2	1	2
Custodial Personnel.....	39	12	0	0	5	8	8	5	1
Hospital.....	31	17	4	0	3	3	3	0	1
Reception-Diagnostic Center.....	29	18	7	0	1	1	1	1	0
Individual Treatment.....	23	11	7	0	3	0	0	1	1
Parole Board and Warden.....	15	11	2	0	0	1	0	0	1
Other Institutions	10	3	3	0	0	4	0	0	0
Miscellaneous.....	9	1	1	0	2	0	3	1	1

last with one referral. Self referrals sometimes requested electroencephalogram tests as well as interviews in order to alleviate any doubts they may have had about their mental stability.

Referrals for treatment was the next largest group with 26 cases. Individual Treatment and the Reception-Diagnostic Center each referred seven cases. The remaining 16 referrals were distributed rather evenly throughout the remaining sources of referrals, with the exception of custodial personnel which made no referrals for treatment purposes.

Non-clinical inquiry was the next grouping of stated reasons for referrals to the clinic. Under this category fell numerous requests for cell changes, new Parole Board hearings, reclassification, and other inquiries of such nature which were not the clinic's function. Self referrals accounted for the entire 24 cases in this grouping.

The next group of 20 referrals was made because of nervousness. Self referrals made for this reason led with six cases, custodial personnel next with five, hospital three, Individual Treatment three, miscellaneous two, Reception-Diagnostic Center one, and other institutions and Parole Board and Warden had none.

Bizarre behavior was the reason given for 18 referrals. Included in this category were such examples as inmates attempting to commit suicide, sleeping under the bed, and other

such behavior. Custodial personnel referred eight cases in this category, while other institutions followed with four referrals. Of the remaining six cases, the hospital referred three, self one, Reception-Diagnostic Center one, Parole Board and Warden one. There were no referrals from miscellaneous and Individual Treatment sources.

There were 17 referrals made as a result of inmates becoming emotionally disturbed. Examples of this group were inmates who experienced delusions and hallucinations. Custodial personnel referred the largest number with eight, hospital and miscellaneous sources followed with three referrals each, and the balance was distributed throughout the remaining referral sources, with the exception of Individual Treatment, other institutions, Parole Board and Warden, who made no referrals for this reason.

Inability to adjust was the stated reason for nine referrals. Of this number, five were made by custodial personnel, while the remaining four cases were referred by self, Reception-Diagnostic Center, Individual Treatment, and miscellaneous sources. No referrals were made for this reason by the hospital, Parole Board and Warden, and other institutions.

"Other" reasons included seven referrals made for a variety of reasons which did not fit into any of the previously stated reasons for referral. Under this grouping were such examples as an inmate's wife requesting guidance as to what she

could do to help the inmate, and a request from the referral source to contact an outside agency prior to making placement plans.

Although custodial personnel referred the largest number of cases in the 1954 study, it was the next largest source of referral in this study. This source referred nearly half of its 44 cases for bizarre behavior in the 1954 study, while psychiatric evaluation was the leading reason stated for referrals in the present study, with bizarre behavior and emotionally disturbed each having eight referrals.

The significance of Table 2 seems to be the contrast of 77 referrals made for psychiatric evaluation as compared to 26 referrals made for treatment. It seems that most sources of referrals view the clinic as more of a diagnostic agency than an agency for treatment. Consideration should be given, however, in those cases where it may be felt that the referral source would feel the clinic should decide whether a referral needs treatment or not. This source would tend to have treatment as the objective, even though evaluation was the stated request.

Table 2 illustrates to some degree what the custodial personnel interpret the clinic's function as being. The majority of their referrals were made for "acting out" behavioral problems that would tend to upset the routine of the prison. Although their referrals did not request treatment,

it is significant that they requested an opinion or evaluation by the clinic in dealing with inmate problems. Custody made 39 referrals, of which 12 were for psychiatric evaluation as compared with the 1954 study which tabulated 44 referrals to the clinic of which only two were for psychiatric evaluation. The former study indicated that 38 of the 44 referrals made by custody were distributed among the categories of bizarre behavior, emotionally disturbed, and inability to adjust. The present study appears to show custody at a period now where they tend to state reasons for referrals that would indicate a desire on their part for obtaining the clinic's opinion regarding the disposition of an inmate's problems. This also could suggest that referrals were made for psychiatric evaluation before an inmate came to the stage of "acting out" his problems, which later could result in bizarre behavior.

Status of Referrals Following Initial Contact

The status of referrals following the initial contact with the clinic were almost evenly divided between those receiving a single contact and those having more than one contact.

Table 3 indicates that of 198 referrals 96 cases received some type of further services following the first interview, while 102 cases were closed following a single contact.

Self referrals tended to terminate after a single contact, with only 13 of 42 referrals receiving further services.

TABLE 3

Referral Sources and Status of Referrals Following Initial Contact, Psychiatric Clinic, State Prison of Southern Michigan, October 1, 1956 - December 31, 1956.

Referral Source	Total	Single Contact	Cases Given Further Contact				
			Total	Types of Contacts			
				Evaluation	Unscheduled Out-Patient Treatment	Scheduled Out-Patient Treatment	In-Patient Treatment
Total	198	102	96	25	7	6	58
Self.....	42	29	13	5	2	3	3
Custodial Personnel...	39	14	25	4	1	0	20
Hospital.....	31	16	15	4	1	2	8
Reception-Diagnostic Center.....	29	13	16	1	0	0	15
Individual Treatment..	23	14	9	6	2	0	1
Parole Board and Warden.....	15	9	6	3	0	0	3
Other Institutions....	10	0	10	1	1	0	8
Miscellaneous.....	9	7	2	1	0	1	0

Custody had 25 cases which received further services, possibly because a greater percentage of their cases were re-referrals.

Other institutions referred ten cases, with that number receiving further services. These referrals were usually made because of circumstances requiring extensive psychiatric examination. Often it was because the inmate had experienced a psychotic episode and was thought to be in need of treatment, or in some cases it was because of future parole plans, and "clearance" from the psychiatric viewpoint was needed as a result of some previous contact the inmate had with the clinic.

Transfer of an inmate from one of the other prisons, requesting some type of service from the clinic, usually entailed in-patient status in the clinic while the service was given. If treatment was involved, the inmate would either be treated while a patient in the clinic or in the convalescent block referred to as "Lower 6". Chronic mental patients also could be transferred to the Ionia State Hospital for the Criminally Insane in some instances where treatment seemed to be indicated for an extended period of time.

The types of services given those referrals who had more than one contact varied with individual cases. There were four types of treatment plans used to describe the status of patients receiving services from the clinic following initial contact:

(1) Evaluation could generally include interviews, psychological testing, and electroencephalogram examinations. Patients being evaluated usually resided in the general population, or were new inmates from the quarantine block receiving these psychiatric services.

(2) Unscheduled out-patient treatment services usually included treatment of some nature on an unscheduled basis. The patient was expected to contact the clinic when he felt the need. He usually resided in the general population, or sometimes was assigned to "Lower 6".

(3) Scheduled out-patient treatment involved at least a single contact with the clinic per week. In some cases patients had more than one contact a week. Patients on scheduled out-patient treatment status often resided in "Lower 6" and were considered to be receiving more intensive treatment than those on unscheduled out-patient treatment basis.

(4) In-patient treatment consisted of the patient being confined to the clinic for treatment. In-patient treatment was considered to be the main focus of the clinic.

Table 3 shows that 25 of 96 cases required some type of evaluation services following the initial contact.

Individual Treatment and self referrals had six and five cases respectively which received evaluation services after the initial contact. These same sources of referrals had two

cases each receiving unscheduled out-patient treatment. The remaining three cases were divided proportionately with one each to hospital, custodial personnel, and other institutions.

There were six cases which received scheduled out-patient treatment. Of this number, three were self referrals, while the hospital and miscellaneous referral sources had two and one respectively.

There were 58 cases that received in-patient treatment services, over half of the total 96 referrals receiving some type of further services after the initial contact. Again, custodial personnel had the leading number, with 20 cases receiving such services. It should be remembered that a large number of referrals made by custody (26 of 39) were re-referrals, and inmates who may well have been former in-patients requiring more intensive services on a frequent basis.

The Reception-Diagnostic Center had the next largest number of referrals receiving in-patient services with 15 cases. The professional services available at this source would suggest that more in-patient treatment cases would be referred, as did occur, as a result of their having available diagnostic services. Patients retained in the clinic from this source tended to be affected by more serious disorders than were custodial personnel referrals. These two sources of referrals had over half of the 58 cases receiving treatment on an in-patient basis.

Hospital and other institutions each had eight cases remain in the clinic on an in-patient basis. There were seven cases receiving in-patient treatment distributed among the remaining sources, with the exception of miscellaneous which had none.

It appears that Individual Treatment referrals received more evaluation services from the clinic than any other service. This could be due to requests for further information regarding plans by Classification and the counselors for jobs, outside placement, and educational assignments.

Clinic Contacts with Referral Sources

The clinic's contacts with referral sources varied considerably. Table 4 indicates that there were 64 referral sources not contacted by the clinic after the patient was seen. From a total of 156 cases, 92 referral sources were contacted. There were 42 self referrals omitted from this total.

Of the 92 sources contacted, 77 sources were contacted within two weeks, while 15 sources were contacted after a two-week period.

Custodial personnel referrals had a good share of replies from the clinic, within two weeks in most cases. Some of their referrals came from sources where no objective could be gained by a reply, which accounted for some of the fifteen cases not contacted. Officers in the yard on night shifts making referrals would be an example of this source.

TABLE 4

Clinic Contacts with Referral Sources, Psychiatric Clinic, State Prison of Southern Michigan, October 1, 1956 - December 31, 1956.

Referral Sources	Total	Referral Sources Contacted			Referral Sources Not Contacted
		Total	Elapsed Time		
			Within Two Weeks	After Two Weeks	
Total	156[a]	92	77	15	64
Custodial Personnel.	39	24	23	1	15
Hospital.....	31	21	16	5	10
Reception-Diagnostic Center.....	29	10	5	5	19
Individual Treatment	23	16	16	0	7
Parole Board and Warden.....	15	14	11	3	1
Other Institutions..	10	3	2	1	7
Miscellaneous.....	9	4	4	0	5

a - Self referrals numbering 42 cases were omitted.

Hospital and Reception-Diagnostic Center were sources which had more cases in which replies to referrals were made after a two-week period. These two sources also had a considerable number of no-replies to referrals made to the clinic. The Reception-Diagnostic Center appeared to have requested numerous electroencephalogram examinations, which in most cases were not followed by a reply from the clinic. The hospital had a considerable number of no-replies to referrals made to the

TABLE 4

Clinic Contacts with Referral Sources, Psychiatric Clinic, State Prison of Southern Michigan, October 1, 1956 - December 31, 1956.

Referral Sources	Total	Referral Sources Contacted			Referral Sources Not Contacted
		Total	Elapsed Time		
			Within Two Weeks	After Two Weeks	
Total	156[a]	92	77	15	64
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Hospital.....	31	21	16	5	10
Reception-Diagnostic Center.....	29	10	5	5	19
Individual Treatment	23	16	16	0	7
Parole Board and Warden.....	15	14	11	3	1
Other Institutions..	10	3	2	1	7
Miscellaneous.....	9	4	4	0	5

a - Self referrals numbering 42 cases were omitted.

Hospital and Reception-Diagnostic Center were sources which had more cases in which replies to referrals were made after a two-week period. These two sources also had a considerable number of no-replies to referrals made to the clinic. The Reception-Diagnostic Center appeared to have requested numerous electroencephalogram examinations, which in most cases were not followed by a reply from the clinic. The hospital had a considerable number of no-replies to referrals made to the

clinic. Because a close relation seemed to exist between certain staff members of the clinic and the hospital, it could be that direct contact or telephone calls accounted for some of the no-replies.

Individual Treatment appeared to have had immediate replies to completion of their referrals. All were contacted within two weeks.

Parole Board and Warden referrals had nearly all of their referrals completed with the source contacted, in most cases within a two-week period. There was only one case in which the source was not contacted regarding disposition. Other institutions and miscellaneous referrals had a number of cases in which the clinic did not contact the referral source upon completion of the referral. This was due in part to the transferring of records and the inmate to this institution, often resulting in some cases where there was no need to contact the referral source. Under the miscellaneous grouping, the maintenance supervisors were seldom contacted.

By and large, a good portion of the referral sources were contacted after the clinic had completed the referral and a disposition made. The length of time before the contact was made appeared to be within the reasonable time of two weeks.

One immediately notices the contacts made by the clinic from those referral sources of Parole Board and Warden. There were 14 out of 15 referrals in which there was an immediate

reply within the two-week period. This might suggest a certain amount of importance put on these referrals. However, this number is not so impressive when viewing the entire picture of clinic contacts with referral sources as shown in Table 4.

Professional Staff Representing Clinic at First Contact

The psychiatrists represented the clinic during the initial contact in nearly half of the 198 referrals. Table 5 indicates that 80 referrals were seen by a psychiatrist. Of the 80 cases, the psychiatric resident saw a good majority of these cases due to his employment on a full-time basis, as well as making preliminary admission notes which were concerned with the possibility of medical problems.

TABLE 5

Professional Staff Handling First Contact,
Psychiatric Clinic,
State Prison of Southern Michigan,
October 1, 1956 - December 31, 1956.

Professional Staff	Number
Total	198
Psychiatrists.....	80
Psychologists.....	59
Social Workers.....	36
Electroencephalogram Technician.....	23

Since the director of the clinic worked on a three-fifths time basis, he did not handle as many referrals as the other psychiatrist. It is also reasoned that referral sources would be more apt to refer cases to the director or to a doctor in the clinic than to other members of the professional staff. This seems particularly true in reference to those referrals from the hospital, Reception-Diagnostic Center, and the Parole Board and Warden. Nearly all of the referrals from other institutions were seen by a psychiatrist at first contact. The possibility of need for medication would undoubtedly account for many of these contacts.

There were three psychologists employed in the clinic, who handled 59 of the 198 referrals made to the clinic. The consulting psychologist represented the clinic in a few cases at first contact.

Social workers represented the clinic in 36 of the 198 referrals. A full-time social worker, who also acted as director of social services in the clinic handled the majority of these referrals. The writer, a second-year graduate social work student working on a one-half time basis, saw a few of these referrals at first contact.

The electroencephalogram technician represented the clinic in 23 cases, usually conducting his examinations at first contact.

The staff member representing the clinic at initial contact changed considerably when comparing these data with the 1954 study. John Davis found that psychologists, with three full-time and two half-time staff members, represented the clinic in 108 of 135 contacts. The difference in additional staff, which compares with three full-time psychologists at the time of the present study, would probably account for the leading figure. Also, the fact that several psychologists had had two to three years' experience in the prison at the time of the 1954 study and were well known, could well account for many referrals being handled by them as a result of their familiarity with many of the cases.

The social worker represented the clinic in 15 of 135 initial contacts in the earlier study. There were two half-time workers and one full-time staff member who handled the same number of referrals at first contact as did the psychiatrist. In the present study, social workers represented the clinic with the third largest group of first contacts, 36 of 198 referrals.

The study found that the electroencephalogram technician represented the clinic in 23 of the 198 referrals during initial contacts. The 1954 study did not report the technician as representing the clinic in any initial contacts.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

This study is concerned with examining the referral and intake procedures of the Psychiatric Clinic at the State Prison of Southern Michigan. The central problem was to determine if there were any differences in the referral and intake process for the months of October 1, 1956 to December 31, 1956 from those of the same period in 1954.

Beginning the study with the intention of comparing findings with those of the 1954 study, certain obstacles arose. In attempting to use John Davis' schedule, it became apparent that a new schedule would be necessary in order to examine current referral procedures. It was necessary to modify the procedure because of the lack of available data John Davis encountered during his study. As a result of devising a new schedule, different data were obtained; however, comparisons were made whenever data sought were of a similar nature to those obtained in the former study. In many instances, this writer made no attempt to compare data as such because of the different information obtained as well as the change of structure in which some of these data were utilized. The tables particularly reflected different findings than those in the study completed by John Davis.

The data found in this study pointed toward a number of significant changes in the referral and intake procedures of the clinic, as compared with the earlier study.

First, there were 198 referrals made to the clinic during the last quarter of 1956. This number was somewhat larger than the 135 referrals made in the former study.

There seemed to be no appreciable difference in the number of referrals made during any one month.

The study disclosed approximately the same number of new referrals as those referrals which had had contact with the clinic prior to this study. The previous study also had a rather even distribution of new referrals and re-referrals.

There were eight main sources of referrals, in which self and custodial referrals were the two largest categories, accounting for 81 of 198 referrals. Self referrals numbered more than those from custody, which had the leading number in the findings of the 1954 study. The remaining referrals were distributed in order similar to that of the 1954 study.

With the exception of the Reception-Diagnostic Center, which was instituted since the 1954 study, the sources comprising the remaining number of referrals were the hospital, Individual Treatment, Parole Board and Warden, other institutions, and miscellaneous, with the largest numbers arranged in the same order.

The Reception-Diagnostic Center was the fourth largest source of referrals, with a total of 29 of 198. This referral source was new; however, a close relationship seemed to exist between this source and the clinic. Numerous contacts were made by the Reception-Diagnostic Center for purposes of further evaluation and treatment. This source did have a considerable effect on the intake procedure when one views the sources, reasons for referrals, and the services given by the clinic. This source had nearly all new referrals, with approximately half of 29 referrals receiving treatment on an in-patient basis. With the exception of custody, which had 20 of 39 referrals receiving treatment on an in-patient basis, the Reception-Diagnostic Center was the leading source of referrals, accounting for 15 in-patient cases. The services these referrals required, as well as the number of referrals made by this source, had a definite impact on the intake procedure of the clinic, when comparing these findings with those of the 1954 study.

The stated reasons for referrals seemed to have undergone some changes since the time of the former study. In using the same categories of stated reasons for referrals, the writer found that psychiatric evaluation remained the most often stated reason for referral, with 77 of 198 referrals. However, treatment was the second most often stated reason for referral to the clinic, with 26 cases. This stated reason for referral was used by the Reception-Diagnostic Center and

Individual Treatment sources in over half of the 26 treatment requests. Custody made no stated requests for treatment, although it used psychiatric evaluation more than any other reason, which seemed to indicate a tendency to use the clinic's services when making decisions regarding inmates with problems.

Approximately half of the referrals were made for psychiatric evaluation and treatment, and were considerably more than those referrals describing behavior which indicated overt disturbances.

Various departments seemed to view the clinic in a different light, which would answer further questions posed by the writer. That is, it appeared that referrals were being made as a result of the sources requesting consultation or opinion from the clinic in helping them arrive at decisions regarding certain inmates. This view of the clinic's function was different in that the former study tended to illustrate that many referrals were made because of extreme emotional disturbances. The present findings indicate that some inmates were being referred to the clinic before they became seriously upset. Another possibility is that those who did exhibit extreme emotional disturbances were referred for treatment and evaluation rather than bizarre behavior, emotionally disturbed, and other similar reasons.

Self referrals had many contacts with the clinic for matters of non-clinical nature. That is, they tended to

request services which often resulted in only one contact, and required less intensive services from the clinic. However, it is encouraging to note that the largest source of referrals came from inmates availing themselves of the services of the clinic by self referral, which indicates positive recognition and acceptance of the clinic's functions.

Custody had twice as many re-referrals as new referrals, which seemed to indicate a tendency to re-refer former patients to the clinic. Some of these patients undoubtedly had been on an in-patient status at one time, and many were re-admitted to the clinic for treatment upon re-referral.

The hospital had half of its referrals receive some type of further service after the initial contact. The majority of those referrals receiving further services commenced some type of treatment, ranging from in-patient status to unscheduled out-patient treatment.

Individual Treatment referred the majority of its cases for psychiatric evaluation and treatment. Less than half received any follow-up services and those cases which had more than one contact often received some type of evaluation service. Only one of 23 referrals from this source became an in-patient. Individual Treatment seemed to use the clinic's services, for the most part, for diagnostic purposes; however, there was an appreciable increase in the number of referrals by counselors, as compared to the former study. Classification

was included with counselors, and most of these referrals requested evaluation from the clinic merely for the purpose of placement.planning. Few received further services as compared to counselor referrals.

The Parole Board and Warden had less than half of their referrals receive further services. Those receiving further services were usually of an evaluative nature. The Parole Board was the source that made up the group having more than one contact. Warden referrals tended to have a single contact and often were re-referrals which were awaiting some type of service that had been scheduled at an earlier date. As an example, a routine examination would be requested after an inmate had been seen by the Parole Board. This examination would be requested from the clinic by an inmate. However, such examinations were not made unless the request was made directly by the Parole Board. What resulted was that the inmate took his request to the Warden, who verified the facts of the case, and thus the referral was merely a re-referral of the patient by a new source for the purpose of evaluation or possible treatment.

Other institution referrals had more than one contact, and usually were made for treatment or evaluation. Many of these referrals resulted in treatment on an in-patient basis. In most cases, inmates who are transferred from other institutions are received directly into the clinic. Evaluation

services generally call for tests and a period of observation which makes it more expedient to have them in the clinic.

Miscellaneous sources of referrals were nearly always cases that were completed by a single contact. These sources appeared to make referrals as a result of inmates becoming overtly disturbed.

After referrals were completed by the clinic, the source of referral was contacted in most cases when warranted. Referrals that came from custody, the hospital, and the Reception-Diagnostic Center had the majority of no-contacts after completion. In many cases, the source was contacted in the form of a telephone call or an individual contact by a member of the clinic staff. This information was not written in the folder, which would make it appear that no contact had been made upon completion of the referral.

In most cases, referral sources were contacted upon completion of the referral. The time in which most sources were contacted was usually within two weeks.

The Parole Board and Warden were contacted after completion of almost all of their referrals. Most contacts were made within two weeks. This seemed to indicate that an extended effort was made to inform this source of the disposition of their referrals. In another light, the referrals made by the Parole Board often were concerned with releases and evaluations regarding parole and discharge plans. This type of

referral would tend to require contacting the referral source after completion of services.

Conclusions

The writer found distinguishable differences in the intake and referral procedure of the Psychiatric Clinic at the State Prison of Southern Michigan when it was possible to make comparisons with those findings of the 1954 study.

The establishment of a Reception-Diagnostic Center appeared to have some effect on the intake and referral procedure of the clinic. This source of referral accounted for the fourth largest number of referrals made to the clinic during the period studied. A majority of these referrals required extensive services and many became in-patients. The writer's question as to whether the referral and intake procedure of the clinic would be modified due to this new source of referrals appears to be answered by the findings.

The sources of referrals seemed to vary in their interpretation of the clinic's functions as compared with the findings of the 1954 study. The writer found that psychiatric evaluation was the stated reason most often used in referrals to the clinic. The former study revealed similar findings. However, in 1954 the majority of referrals were made for "acting out" behavior rather than for any specific plans for treatment. The present study saw psychiatric evaluation and treatment accounting for half of all referrals. These findings

would seem to indicate that referral sources view the clinic in a different manner than the 1954 study would suggest.

The writer is of the opinion that further studies in this area would provide an excellent basis for perpetuating a record of the Psychiatric Clinic's relationships with the various departments within the prison, and the Corrections Department as a whole. And further research, interpretations, and comparisons of such findings might prove valuable toward implementing the aims of the Psychiatric Clinic in rendering the services for which it was inaugurated.

APPENDICES

SCHEDULE USED IN COMPILING DATA OF CLINIC CONTACTS
October 1, 1954 - December 31, 1954

1. Number_____Referral Date_____Referred By_____

2. Stated Reason for Referral_____

3. Initial Contact_____Date_____

4. Prior Contact During Preceding Year_____

   (a) If so, Nature of Contacts_____

   (b) Reasons for Contacts_____

   (c) Disposition of Case_____

5. Chronic Mental Patient_____or Series of Contacts Prior to October 1, 1953_____

   (a) Prior Status in Clinic_____

   (b) Disposition of Case_____

This information applies only to Contacts of Three Months Prior to period, October 1, 1954 - December 31, 1954:

1. Who had Initial Interview_____

2. Further Contacts_____

3. Same Person_____If Yes, When_____By Whom_____

   For What Purpose_____

4. Was Case Staffed____When_____Formally___Informally___

5. Status of Case During This Time: (a) Call Basis_____

   (b) Visitor____(c) Out-Patient____(d) In-Patient____

6. Disposition: (a) Released____(b) Carried on Caseload____

   (c) Treatment_____(d) By Whom_____

7. Diagnosis_____

   _____

REFERRALS TO PSYCHIATRIC CLINIC
October 1, 1956 - December 31, 1956

1. Number_____New Referral_____Re-Referral_____

2. Referral Date_____Referred By_____

3. Stated Reason for Referral_____

_____

4. Date of Initial Contact_____With Whom_____

5. Single Contact____Further Contacts (within 3 months)____

With Whom_____

(a) Types of Contacts:

1. Evaluation_____ 3. Scheduled OP Rx_____

2. In-Patient Rx____ 4. Unscheduled OP Rx____

6. Length of Time Between Referral and First Contact_____

7. Did Psychiatric Clinic Contact Referral Source_____

If Yes, Was it:

(a) Within Two Weeks After Completion of Services_____

(b) More Than Two Weeks After Completion of Services___

8. Diagnosis:_____

_____

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Oral Communication

Psychiatric Clinic Personnel, State Prison of Southern Michigan:

Wille, Warren S., M.D., Director

Steininger, Edward H., Psychologist

Martin, James G., Psychologist

Dukes, Harold, Social Work Supervisor

Diple, Frank, Inmate Clerk

Mills, Robert, Inmate Clerk